PASSPORT to Health Summit
Kalispell
June 8, 2005

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Examine the four objectives of the PASSPORT Program

1. Foster a medical home between provider and clients

a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly**?

- Recently PP has taken more ownership of the clients than in the past.
- For consumers, get access and expedient care to whomever and whenever.
- Less abuse of the system, especially with elements like Nurse First and Team Care.
- Better communication between clinics for drug-seeking and other clients. It gives us the ability to get more information before we treat and over-prescribe drugs.

b. **What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?**

- Providers give the consumer blanket permission to see whomever they want.
- They are assigned by county. Consumers appear on the list after being moved from another PCP, and consumers feel they are being denied access.
- It's hard for the provider when an emergent patient walks in. We can't get the patient's PP number. We had to have our doctor call the medical home office to get a response.
- If we do give PP approval for emergent care, then the patient needs care by a specialist. There is an insurance liability issue AND we've never seen the patient. Ripple referrals take place with authorizations without ever seeing the patient. The doctor isn't doubted, but we need back-up documentation.
- What does authorization mean versus referral?
- Refusals take place for referral requests, with those that are auto-assigned. The medical home has never seen the patient and refuses.
- There is a misunderstanding about the ability to give us the PASSPORT number.
- The mother of a new baby goes to a pediatrician out of town who is her PP, AND she wants to go a closer, local doctor for smaller conditions like colds.
- If we refuse it, it makes us the bad guy.
- Hospitals admit patient and are penalized while the provider, specialists, and others fight out the authorizations.
- You can't get hold of providers to get approval.
- We are not obligated to see the patient, just SCREEN them. People with colds aren't seen; they are told to go their PP, but to avoid waiting they go to the ER.
- Doctors and nurses at emergency rooms don't turn patients away. There is a concern about the potential for angry behavior if we do turn them away.
- Patients mis-identify what an emergency is.
- The clinic in Cut Bank is very close to the IHS in Browning. It's tough to get approval, and the IHS is easier to get into. The clinic, therefore, takes it in the shorts because we don't refuse care.
- Nurse First is wonderful, but during the day a patient was directed to the emergency room. Is there a profile that dictates this for asthma?

c. **What do you suggest for the future? What other arrangements could better meet this objective? What do other payers do that you would like to see PASSPORT emulate?**

- Clarify when it's okay and not okay to give out the PP number.
- Put more responsibility on the patient. Emphasize the use of Nurse First as a first step for patients.
- Make patients pick a provider, and if not, don't give them a card.
- Don't allow patients to change PPs every month. They do so on a whim.
- I'd like to see MEPS for PP availability. It doesn't match. We have claims denied for various reasons.
- A system of PPO when the clinic is close to the IHS. Getting approval is tough.
- Maybe Medicaid could have a plan for when you can't reach the PP, and the patient needs care. Institute the ability to call Medicaid and get an override for that day.
- Make Nurse First part of PP authorization.
- Make an override in the system when a referral is made, to automatically make it an authorization.
- Once a patient is in the hospital, PP should be irrelevant. But what if it's an elective procedure?

2. Assure adequate access to primary care

a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?**

- We use the list of patients to remind them of wellness visits and stay in contact with them.

b. **What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?**

- What is adequate access? This population seems to think everything is emergent.
- Patients won't see Physicians Assistants or other doctors in the group, or other mid level providers. If they don't want to see who is available, two things happen: 1. Later that night they go to the ER, or 2. They go down the street to another doctor.
- Our emergency room is used like a clinic; it is about "When can I be seen with no waiting?"
- The busiest time is between noon and 2:00 PM, and after 6:00 PM. They know how to manipulate the system.
- Patients know they won't be turned away.
- Clients and clinics themselves report that people are turned away because co-pays haven't been paid. No one should be denied care.
- A problem exists of patient coming in without the co-pay.
- What is the point of the co-pay?
- People report being denied for not paying the co-pay, and the provider gets yelled at for "refusing service."

- We are not reimbursed for the over the counter medications we distribute and clients can t afford them.
- There is an access challenge for new Medicaid clients, with too few doctors.
- It s difficult in hospitals to know and keep track of what the co-pay amounts are. There is a challenge of treating all patients equally if the co-pays are written off.
- Going after co-pays is not worth the time.
- We always ask our employees to do more with less.

c. **What do you suggest for the future? What other arrangements could better meet this objective? What do other payers do that you would like to see PASSPORT emulate**?

- Get rid of the co-pay.
- Make a cap on the co-pay amount. Then Medicaid pays for co-pays after the cap is reached. Then abusers of the system will be easier to identify.
- Provide an incentive. Patients are apt to follow the rules because so few doctors take Medicaid.
- Provide more education to and require more accountability by patients.
- Send patients to collections; treat patients equally.
- Provide more information on MEPS about co-pays.
- Educate clients with face-to-face interactions. Provide day care. Hold town hall meetings for both clients and providers in each community.
- Educate clients when they enroll; go beyond just handing them the book.
- Make attendance at a training a requirement before they receive their cards. Partner with other service providers to provide this training.
- Or give them a card and tell them they must attend or lose the benefit.
- Partner with people who handle financial counseling and qualifying for Medicaid. Ask them for help.
- Encourage thorough education and training for eligibility case workers.
- Create simple kiosks with computers or power point presentations with information about Medicaid as well as prevention suggestions, and put them in clinics and Medicaid eligibility offices.

3. Encourage preventive care

a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly**?

- The lists of clients help us remind people to come in.
- The letters sent to patients work well and are referred to.
- Coordination with VFC on vaccinations is working well.
- Allowing well child and sick child visits on the same day is very helpful.
- There are several oral surgeons in the Flathead Valley taking Medicaid.

b. **What doesn t work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?**

- A lot of dental problems come into the emergency room, especially with adults.

- There is only one dentist who sees Medicaid patients.
- By the time we see the patient, they need an oral surgeon, not a dentist.

c. **What do you suggest for the future? What other arrangements could better meet this objective? What do other payers do that you would like to see PASSPORT emulate**?

- Health newsletters for patients would provide an opportunity for education.
- The kiosk idea would allow a standardized education regarding wellness.
- Make it more clear on coverage of wellness exams, like bone density exams. Most insurance providers distribute a list to patients about what is covered and what is not.
- Provide patients a list of facts and history to share with their provider. This is done for children at two weeks of age, so it's duplicative, but do this for kids.
- Waive the co-pay on wellness visits to encourage patients to come in.
- Cover adult immunizations. [Most are.]
- Foster preventive care statistics and reports. There is a downward trend as people age. Identify why this occurs.
- Do the data analysis on the whole population regarding preventive care utilization. Coordinate with MEPS enhancement.
- Promote annual dental wellness checks. Build in an allowance for repair at the same time.

4. Reduce and control health care costs

a. **How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly**?

- With Nurse First and Team Care, frequent visitors are coming a lot less often especially those who don't need care.
- Using MEPS is reducing my costs versus faxing and waiting for call backs.
- We can do more preventive care as our costs go down.
- Reader machines are the best things we ever bought.

b. **What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective**?

- With Team Care, we still see a lot of patients coming into the ER, especially for drugs. Some ERs only provide a lessor drug or don't distribute drugs at all.
- What data identifies a person with Team Care? Medicines don't show up.
- Participants' cards doesn't mean they are on Medicaid – or not.
- The number of the card is not the number you use to bill. (This was changed recently and you can now bill with the number on the Medicaid card.)
- I didn't know about the reader machine and what it identifies.
- Without a scanner, the staff time costs of getting on the internet and calling for authorization is excessive.
- Patients say they don't want to wait, so they go to a walk-in clinic or ER. It's a slow process. We sit and wait for return calls, tying up my staff who is already stretched.
- The PCP lets them be seen elsewhere, collect the monthly fee – and never sees the patient themselves. Some PCPs don't allow appointments to see these patients,

and always say "Go ahead and see them." A lot of patients don't even know who their primary is, and have never seen them.
- The process of changing numbers and we're denied because we have the wrong numbers. We're gaming the system.
- We call for authorization and get the wrong number, and then are denied payment.
- IHS sees a huge abuser of ER. We receive daily faxes from the ER, asking for us to pay. The majority of patients are Medicaid. We review notes and deny visits that are non-emergent. As far as we know, Medicaid is paying for everything.
- The patient's perception is they deserve care and their definition of emergent care is an issue.
- Patients could have gone to their provider for a drug, but wait until night and go to the ER.

c. **What do you suggest for the future? What other arrangements could better meet this objective? What do other payers do that you would like to see PASSPORT emulate?**
- Waiver process to increase numbers of people covered.
- New health care purchasing and employer incentives.
- New prescription programs and discounts and increased numbers qualified.
- Provide a reader machine to all clinics.
- Reduce the provider responsibilities and liabilities. We eat the bills.
- Educate the clients on these matters – the cost they pay versus the real costs, and the value of smart decisions about their health care.
- Don't change the numbers. Some of our claims are six months old. I'd have to go back. Bag the quarterly idea.
- Make the ER co-pay higher, like $40. Another perspective: They can't afford it; the provider would then be stuck with it. This would be okay if the total reimbursement from Medicaid is static.
- Put something in place to take some of the medical liability off the ER's back. Create a vehicle to make ER doctors more comfortable in refusing care, so they can refer back more to the providers, versus working them up completely. Find the balance. Make them call Nurse First in ER before any service is administered. Another perspective: This will never happen. This is what is done in Texas. How do they do it and avoid discrimination? Look at the liability issue involved with this problem.

Create your own model small work groups proposals

Model A suggestions

1. Make clients more accountable. Hold orientations so they take ownership like other insurances.
2. Be able to bill patient if denied by doctor.
3. Make it more like the CHIP program.
4. Higher reimbursement be paid for what we bill for.
5. Educate clients on costs within health care system, the loss experienced by facilities, and the ER costs versus clinic fees.
6. Make the card more useable. Distribute provider card readers.
7. Quit enabling clients. If they have no card, make them become private pay.
8. Require clients to choose their PP provider right away!
9. Encourage better and more use of the Nurse First line.
10. If the person is unable to contact PP, have clients call Nurse First for referral and a pre-authorization number.

Model B suggestions

1. Planning committee should include representation from selected specialists.
2. Medicaid should provide their PCP with the swipe machines.
3. Educate offices on the rules of PASSPORT authorization.
4. Make patient education mandatory before they receive a Medicaid card.

Model C suggestions

1. Preferred Provider Network system:
   - No authorization needed within the network.
   - Have a primary care physician. Share a network identification; make the delivery of services more seamless.
   - If the person doesn't belong, they need authorization.
   - Make authorization numbers unique.
   - List of procedures needing special authorization.
   - If using the network, don't charge a co-pay.
2. Have states integrate Medicaid systems for payment. Similar to Blue Card system.

Model D suggestions ..... a PPO design

1. PASSPORT Provider:
   - No more management fee for provider.
   - Patient doesn't pay a co-pay.
   - The provider gets co-pay as additional payment from Medicaid for each visit.
2. Non-participants, including hospitals, surgeons, and other PCPs:
   - Co-pay is applicable and required.
   - No PP authorization is needed.
3. During eligibility process the person must complete an orientation.
   - Client must sign a statement saying they understand the benefits, requirements, what causes dis-enrollment, and preventive and wellness information.

4. Abuse of non-payment is tracked and is a basis for dis-enrollment.
5. Medicaid clients are required to call Nurse First after an ER visit. Nurse First tracks the data to find non-emergent visit. Educate the clients and have criteria to dis-enroll.

Model E suggestions

1. PASSPORT providers keep the same numbers.
2. If the referring physician is a PASSPORT provider, no authorization is needed.
3. A quicker way to identify eligibility and PASSPORT, such as monthly cards. Provide the equipment. (Medifax or on-line MEPS.)
4. Make patients accountable:
    - Mandatory in-service training at time of enrollment.
    - Remove minimal co-pays.
5. Make it mandatory to call Nurse First before presenting at the ER for non-emergent services.
6. Work on enrolling more dentists, such as by increasing reimbursement or other incentives.
7. Educate patients on the costs and loss of treatments at facilities.
    - No pre-authorization for in-patients with medical necessity.

Feedback and suggestions about Referrals

Security?
- Don't have referrals!

Audits?
- Yes, but what is the punitive result?
- If PCP logs them, keep a record of who you talked to.

Should a specialist document it? Yes!

Suggestions:
- Electronic referral number that includes a secret number.
- An override referral from someone inside Medicaid. Use Nurse First, but it only recommends care.
- Give emergent care a special modifier when it truly is, so they can be paid. Put something in the box to indicate emergent. Have it accompanied by the doctor's notes.
- Holidays and closed offices present a problem. It's not an emergency, but the child is quite sick.
- What is reasonable for how soon a routine/sick/urgent visit will take place? Create a standard like private payors have. How do HMOs handle it? To call the HMO or the state, medical staff would have to be hired.

Quarterly idea? No!

Increase the client's responsibility in getting referrals?
- Won't happen!
- Why not?
- Create consequences (such as they can't be seen) if they don't have the right piece of paper with them. They are used to experiencing no consequences, so they don't care. There is both in-efficiency and a cost issue too if we send them off to get it. It puts a lot of pressure on the PCP.

Should we require standardized forms?
- It's easier to pick up the phone.
- No forms.
- It should be up to the PCP and his/her nurse. Then, like an x-ray order, it's documented and put in the file.
- What if the doctor isn't in the office or near a fax? Currently we back-date them.

Electronic referral?
- Are enough PCPs on line?
- Billings would require a separate person.
- Front desk people in doctor's offices aren't on-line.
- Make it a phone-line access.
- Calling puts the information on both ends.
- Referral to a hospital like OT or PT should automatically be an authorization.

What should ALWAYS require a referral?
- Same day surgeries.

What should NEVER require a referral?
- Speciality services.
- If the ordering physician is the PCP.
- Emergent cases.

Feedback and ideas about improving education about the Program

1. With service providers
    - We would love to have you visit.
    - Medicaid list serve to announce changes and provide update notifications.
    - Summits like today. Shorter ones.
    - Office visits at lunch hour with food to encourage doctors to attend. Yes, continue these.
    - Send nothing to doctors in the mail; it doesn't get read.
    - When visiting, hit various locations. Consider the cost of travel to small offices.
    - Invite the PASSPORT staff to staff and association trainings.
    - Target those offices who you get the most complaints about, and those who don't show up at trainings. Go see them.
    - Medicare and Blue Cross have coordination meetings with providers – a users' group to have quarterly round table discussions. Doctors could come with his/her office manager.]
    - Pick specialists to insure input from everyone.
    - The provider education that takes place now works very well.
2. With patients
    - Increase the orientation.
    - Hold town hall meetings, like this Summit. Provide day care.
    - Make something mandatory or it won't happen. They don't care. Have a position / person to provide this.
    - Identify: What are their issues? What are the barriers?
    - We could include Medicaid benefits education.
    - Send benefits people to places like Libby to explain the programs available to them.
    - Remember, it's not one size fits all – urban/rural, Reservations, etc. Cater the education to the audience.

Individual participant worksheets

1. What do you most want the Program to consider from today's conversations?

Hospital or providers at a hospital:

- Orientation at time of eligibility.
- Clients need to be more accountable for the services they seek and from whom. Eliminate or manage clients' co-pay.
- Patient responsibility and accountability.
- Training for clients during or shortly after enrollment – Nurse First.
- Do away with co-pays less than $100.
- There is obvious frustration from the provider community. Listen to the common themes.
- Get rid of co-pays. Get rid of PASSPORT doctor (PCP). Not working; hurting providers.

Billing office staff or office managers:

- Simplify access to PPDR numbers.
- Make patient responsible for PASSPORT authorizations (in hand written authorization with number). Eliminate co-pays or bank co-pays and Medicaid pay them from client-banked funds.
- Develop on-line access and referrals that are quick and easy to use and develop:
  - Card swipers.
  - Enhanced MEPS.
  - Possibly removing PASSPORT numbers and this requirement.
- Make the client responsible – educate. Help non-PASSPORT Providers work with the PASSPORT Providers more easily.
- No hard cards or else free MEPS. Education for clients. Co-pay changes.
- Mandatory education for consumers. Emergent services provided at a clinic who is not PCP and unable to get authorization number. Medicaid being able to over-ride.
- Put more emphasis on the selection of the PP. More cooperation from the PP provider when obtaining authorization. Having the PP contact the client if they want them to change PP.

PCPs:

- Better education of plan to clients – required. Improvement of card. Educated all providers - PCPs on PASSPORT approval / referral. On-line referral system.

Others:

- The ideas of the role models.
- Understand the frustrations of the PCP office with lack of responsibility on Medicaid clients' part.

2. What do you find the most frustrating about the current approaches?

Hospital or providers at a hospital:

- Hospitals get penalized for what the PCPs do wrong, such as authorizations / forms not

filled out.

- PP not taking an active role on their clients, such as allowing them to see whomever, whenever. Too much abuse by clients. They feel they have a "ticket to immediate care."
- Taking time out from billing to obtain approval for patients' visit. Specs, surgeries, etc. Have patient bring letter at time of visit showing PASSPORT authorization, making it their responsibility. This letter of authorization could be a phone number for us to call to receive PASSPORT number so patient wouldn't be privy to this information. ☺
- Lack of communication from the Department. This meeting was a very good first step.

Billing office staff or office managers:

- Unnecessary!
- Client is not held responsible.
- The time it takes to receive PP approval. Taking all responsibility while the client has none.
- Hard cards – eligibility. Co-pays. Clients come in and say "I didn't know that" about co-pay.
- Reimbursement. No accountability of consumers.
- Trying to get the PP authorization for clients to get specialty care.

PCPs:

- Patient not paying co-pay. Receiving PASSPORT.
- PASSPORT authorization.

Others:

- Labor intensity in PCP office.

3. What would make you a champion and supporter of PASSPORT, and truly advocate for it?

Hospital or providers at a hospital:

- Making clients responsible.
- Client accountability!
- If it was made easier to obtain the authorization needed and made understandable to the provider as well as the client. As it stands now, the PASSPORT authorization is just another deterrent in getting paid an already minimal fee for services. Make it less time consuming and more attainable.

Billing office staff or office managers:

- Simplify the process.
- Make processes as simple and with as little bureaucracy as possible.
- Patient education from the system.
- Put these people to work or something. Make them responsible for "their" insurance that we are paying for. Not all, but some are using the system. If I have questions about certain ones, can I give you their names to check them out?
- Cooperation with PP.

PCPs:

- It's a great program for the clients that truly need it and use it appropriately. Unfortunately, there are many clients that abuse the system and take advantage of it. I hope these Summit meetings will help to improve the system. Necessary to educate clients and PCP both.

Meeting evaluations summary

1. What were the **most** productive or helpful or interesting segments of today's meeting?
   - Problem solving from all brainstorming.
   - All the input and experiences.
   - Allow for open discussion.
   - Open discussion regarding ideas, issues, etc.
   - The interaction and information from other provider groups.
   - PASSPORT staff seemed very open minded about suggestions and complaints.
   - Group models.
   - Group participation. Provider - ACS communication.
   - Feedback from all types of providers, PCPs, hospitals, etc.
   - Interaction between provider was great. Good ideas!
   - The open discussion from different entities.
   - Seeing what might be coming. Knowing that you're all there (a phone call away) if we need help.
   - Listening to the views of other providers.
   - Sharing ideas and concerns with other providers.
   - Excellent interaction from various entities. Excellent facilitation of meeting.
   - Discussions and round tables.

2. What were the **least** productive or helpful or interesting segments of the today's meting?
   - Prolonging the subject. Less complaining.
   - Long objectives.
   - The groups create your own model.
   - Hearing the same issues that do not have resolutions.
   - Going over the same things. Can't help it, I know. Toooooo longgg!!!
   - Too much repetitiveness.
   - Thought all good.

3. Did you **accomplish** what you wanted to accomplish? If so, what subjects or issues or topics were they? What, if anything, did you get out of the meeting?
   - Yes. Looking forward to outcome and reporting back future plan.
   - Yes. All. Understood other PP frustrations.
   - Yes. It seemed that representatives from Medicaid were very open to listening to ideas and issues.
   - Yes. (Two people had this answer.)
   - Will wait for response from ACS / PASSPORT.

- Yes. Being able to voice our opinions were great. The role of the non-PASSPORT provider.
- Yes. More knowledge, sharing frustrations.
- Partly. I still would like to know exactly how we don't take on a client. Also, do we have to see them if they are on our list? Do we have to give them three tries? Where is our provider agreement? Maybe it needs to be changed.
- More patient responsibility and accountability.
- I feel we were all heard.
- Yes. PASSPORT referral discussions. Eligibility options.

4.a. What **changes and improvements** do you suggest for future meetings like this one?

- A little shorter.
- At least a little bit longer breaks.
- Not such a long discussion on the objectives.
- None.
- Try to get more specialists here.
- Shorter seminar.
- Afternoon snack.
- Make it a little shorter.
- More fun things intermittently, just to break up the monotony of generating new ideas. Need to be kept fresh and clear thinking.

4.b. What would you like to have left **exactly as it was** at this meeting? Keep these characteristics:

- Everything.
- The role models were great.
- Structure of the meeting was great.
- Everything.
- The interaction from everyone.
- Brainstorming was great.
- Open discussion.
- These meetings are very informational. And the food is always good. And everyone REALLY answers questions!
- The wonderful staff that remained open-minded through all the complaints.
- Lists on walls. Number of Medicaid personnel available to answer questions.

5. Any feedback about the materials you received prior to the Summit?

- Very complete.
- First Summit I attended.
- No.
- Very informative.

6. Any other feedback, suggestions or ideas?

- Keep up the good work.
- I liked that we had someone to keep the meeting on track and moving.
- The whole program was very helpful and productive.
- Thanks for coming.
- We are a very small Doctor's office. Just one doctor, one front desk, and myself. We are not

on-line and we use a MAC computer. That is a big problem, I know, for us. I'm not sure if we could afford to update. I actually get the Medicaid news on my home computer but haven't looked at it because my computer is old and crashing.

- Thanks for your time and effort.
- Keep educating and updating providers.